



A SOCIOHISTORICAL OVERVIEW OF HARM REDUCTION DEVELOPMENT IN CROATIA

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ABSTRACT

Harm reduction is viewed as a public health aspect of drug policy in Croatia. The development of needle exchange programs and opioid substitution therapies are discussed herein by sketching the basic contours of the Croatian social and cultural context in which these activities have taken place over the past several decades. Along with the critical reflection of the approaches in which drug use in Croatia is considered in the matrix of anomie and disorganization explanations, two phases were identified in the development of harm reduction programs. The first phase marked the initial establishment of these programs in the context of strong growth in the number of heroin users in the 1990s, while the second phase allowed for the further development of these programs during the 2000s. It has been shown that, in contrast to anomie and social disorganization related approaches, the economic and political development trends of Croatian society are not clearly unambiguous in relation to the development of harm reduction programs, thus indicating that consideration of harm reduction development is more appropriate to link to the decentralization of related activities and the incorporation of these programs into intravenous drug use population's social insurance. In this way, immediate and non-patronizing access to the intravenous drug use population throughout Croatia is enabled. However, although embedded in the prohibitionist government's drug policy, the current implementation of the harm reduction programs in Croatia is still characterized by the unpredictability of official drug policy action as well as the general changes in drug use, with problems associated with the use of new psychoactive substances representing the greatest challenge.

KEY WORDS

harm reduction, drug policy, needle-exchange, decentralization

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INTRODUCTION

The issue of drug related benefits and harms is inherent in the use of various psychotropic substances and is historically framed by features of the political, socio-economic, and cultural context in which it takes place [1]. During the 1980s, in the context of a global prohibitionist drug regime that was further emphasized in some leading industrial societies through the War on Drugs policy, the subject theme of harm reduction appeared as the backdrop of numerous reports of the devastating consequences of intravenous drug use. Bewley-Taylor points out that the problem was recognized by different actors who had been working with the intravenous drug use (IDU) population in Europe, Oceania, and parts of North America, and comprehended largely in terms of the spread of HIV/AIDS and Hepatitis C (HCV) as the most significant blood-borne infections [2].

Since then, the term has become recognizable and widely used, mainly through its simultaneously narrower and broader meanings. On the one hand, in practical terms it most often refers to a form of direct action toward intravenous drug users (needle exchanges, opioid substitution programs, etc.), while on the other, it implies questioning the dominant drug policy and is used in various ways - denoting a “principle, concept, ideology, policy, strategy, set of interventions, target and movement” [3]. Harm Reduction International (HRI) suggests that there is no comprehensive and generally accepted definition. However, HRI approaches harm reduction as a term that refers to “policies, program, and practices that aim to minimize the negative health, social, and legal impacts associated with drug use, drug policies, and drug laws. Harm reduction is grounded in justice and human rights – it focuses on positive change and on working with people without judgment, coercion, discrimination, or requiring that they stop using drugs as a precondition of support” [4].

In regard to the aforementioned multiple meanings, a corresponding diversification is visible in numerous scientific research where it is comprehended through ideological turns in the development of both harm reduction movement and official agendas in public policies of particular countries [5]; discursive features of context with drug user as its key actor [6]; ethnographic findings on drug use scenes, lifestyles, and drug use practices [7]; and a consideration of the main ways in which the public health perspective views harm reduction [3] etc. Putting the term aside for a moment, some studies have indicated that when it comes to the unwanted consequences of drug use, the approaches that focus on the harm reduction has long been at work, dating back throughout the history of humankind, and more specifically through efforts aiming at risk minimization in the 20th century [2]. From this perspective, the concept of harm reduction could be widely absorbed into the mainstream approach. Nevertheless, this perspective also has its critics as well – for example, Ettore [8] argued that harm reduction represents a business philosophy drawn from the health and insurance industries and applied to a different use field, and as such may have some value but should be nuanced, primarily through its gender dimension.

Ball points out that, so to speak, a binary opposition between narrow and broad definition of harm reduction still exists and is “hotly debated” several decades after the onset of the HIV epidemic [3]. Maybe it’s not so surprising, because any discussion on drug use is emotionally driven with ideological and often uncompromising stances. However, Fromberg [5] claimed that already in the 1990s the ideological disputes behind the harm reduction became more perplexed when the basic views on drug use were related to attitudes toward the legal status of drugs.

In the area of drug policy, harm reduction most often represents a public health approach aimed at a targeted population of intravenous drug users (IDU), but applicable to other types of risky drug use. In this context, harm reduction includes interventions, programs, and

policies that seek to reduce the health, economic, and social harms resulting from the use of drugs by an individual, group, or community [9]. In some studies, such actions are based on the assumption that, in order to reduce the harm intravenous drug users inflict on themselves and others, assistance should also be given to those drug users who are unable or unwilling to relinquish their addiction [10]. Although this is an incomplete designation which implicitly suggests that drug users are at the same time the only actors in creating drug-related harm, the associated values suggest harm reduction as a health alternative to an inpatient model in which addiction is viewed through a matrix of morality and criminalization. This means that abstinence may be the preferred outcome of addiction treatment, but alternatives that primarily reduce the harm caused by drug use are accepted. Action is directed at needs articulated by IDU users themselves and not predefined by policies based on unrealistic and highly moralistic goals. Through harm reduction, drug users are allowed to access and seek help from the services charged with dealing with them without moral obstacles and conditions. In other words, as a public health approach, harm reduction opposes moral idealism and the unrealistic ideals of a drug-free society, while promoting pragmatism based on the belief that drugs have always been used in human societies in different ways and with different purposes and outcomes, and are likely to be so in the future [10].

In technical terms, the harm reduction policy currently covers several core interventions. These are, first, programs for anonymous and the free replacement of syringes and needles for intravenous drug use, which include the work of mobile teams operating in places where intravenous drug users are located and fixed locations where users can bring already used equipment and exchange it for a new one. The second type of intervention refers to the establishment of counseling centers where intravenous users can obtain all kinds of information about addiction, IDU-related infections, and corresponding topics. Third type refers to the drop-in centers, i.e., places open 24 hours a day and available to intravenous users, including a number of homeless addicts, to meet the basic needs, such as showering, changing clothes, and getting warm meals. Fourth are injecting rooms, i.e., spaces where users can inject drugs freely with the use of sterile accessories and with the unobtrusive presence of professional staff who can intervene in cases of an overdose and other consequences of risky behavior. Finally, the fifth form of intervention involves the organized distribution of substitution therapy, with methadone maintenance therapy (MMT) remaining dominant. More recently, “the mixed opioid agonist/antagonist buprenorphine is being used with evidence suggesting that it may usefully complement methadone, especially in cases where people may be moving toward a reduction in use” [2].

Given that Croatia is a signatory to all key UN conventions that define the framework for drug prohibition policies, in this article we are dealing with a sociohistorical overview of the basic social contours in the development of harm reduction policy as an approach that has (at least partially) established itself in the Croatian officially prohibitionist and strictly abstinence-oriented ideological and political environment. In this regard, several stages of harm reduction development in Croatia are considered. These developments have not questioned the dominant abstinence-oriented political paradigm, but nevertheless opened the door for challenging the official drug policy as being inappropriate and sometimes completely powerless in solving the problems arising from risky forms of drug use.

This article discusses the elements of the social context, especially in the development of needle exchange programs, because it is a type of intervention that has been synonymous with harm reduction programs in Croatia for the past thirty years. Although the opioid substitution program has been developing over the same period, it is, in contrast to the referent literature, considered primarily in terms of the treatment of addicts and placed beyond the chapter on harm reduction in documents that shape Croatian drug policy [11-13].

Given that illegality is a common feature of the use of various substances (previously known or new, but also those incorporated into “public knowledge” as “soft” and “hard” etc.), the developmental stages of establishing harm reduction could not be considered without observations related to the social context of drug use in general. The relatively small number of scientific studies in the social context of drug use in Croatia has additionally contributed to this approach.

EARLY DEVELOPMENTS IN DRUG USE

Illegal drug use began in Croatia in the 1960s, and its rise in use has been occasionally interpreted in epidemic terms, and has become recognized as a social problem during the 1980s, most notably through the growing number of heroin users in some Croatian cities, the emergence of new synthetic drugs, and the somewhat normalized images of cannabis smoking. The Croatian social context of drug use during the 1960s and 70s has not been scientifically researched and is indicated by a number of clues about the former Yugoslavia as a transit country, i.e., the trafficking (Balkan) route, about the types of drugs used in the beginnings of fragmentation of youth subcultures and about the specific places in large cities where drug users began to gather during that time [14-16]. Since we could not find a source offering the sociodemographic features of the then users, we may refer only to subcultural explanations that insist on the primary importance of cultural contrast to a society in which socioeconomic differences are manifested in social consciousness through representations of the predominance of middle class [15, 17-18].

However, not all drugs appear in the same proportions and at the same time. Sakoman [14] indicated that heroin appeared more significantly in the early 1980s when amphetamine powder (also known as “speed”) and cocaine use were low, while inhalant use had become recognizable in the mid-1970s. By that time, various drugs were taken, often all that would be found “at hand”, with the hashish, pills, LSD and opium being the most common.

The first addictive careers began to form in the mid-1970s. In regard to the presence of opium and pills among users, breaking into pharmacies to procure morphine, codeine, ephedrine, and other opium preparations was one of the more striking patterns of drug procurement [19]. Essentially, illicit drug use manifests itself in a way that can be largely captured in terms of subculture. Subcultural elements thus integrate the processes of creating symbolic structures (which, in individual and collective forms, indicate a departure from socially dominant attitudes to drugs) with real problems arising from the fact that taking illicit drugs can result in imprisonment, psychiatric diagnoses, and various deviant labels, preventing any discourse on normality and opportunities for successful maneuvering in everyday life – like finishing school, finding a job, or establishing the preconditions for differentiating drugs and solving addiction problems, etc.

Drugs were not a common component in the adolescent stages toward adulthood, but rather the choice of a minority that was committed to their effects: some former users reported that opium was more prevalent than heroin during the 1970s, but this does not fully match the assertions in corresponding literature [16, 19].

Illegal drugs and their use will remain poorly visible until the mid-1980s. However, this could imply that the small number of specific places where drugs were used was relatively easily identified and often mystified both by users’ subcultures and social control services, with images that only partially correspond to the real situation. In the 1970s and 1980s, some places in major Croatian cities gained the status of a negative symbol (“drug addicts’ gatherings places”) and were somewhat differently indicated and described in the literature [14-15, 17]. With basic indications of youth subculture fragmentation, but not exclusively in accordance with it, by the mid 1970s drug use scenes had separated in Zagreb [17, 20], suggesting that soft and

hard drug use corresponded to some extent with other subcultural preferences, but nevertheless brought together all drug users with regard to the illegal status of both cannabis and heroin.

Data on the number of heroin users for the whole period are fragmentary and largely based on estimates. Kušević [19] estimated that 5-18 % of heroin users enter the system that was not based on any of the modern harm reduction practices. According to data from the then Center for Psychoactive Drug Problems (which was established by the Institute for Health Protection of the Federal Republic of Croatia), Kušević estimated that the number of heroin users in Croatia ranged from approximately 2 000 to 7 000 in 1985. However, it is only possible to speculate on the number of heroin users to whom the assessment relates. In any case, Kusević pointed out that until the second half of the 1980s, the numbers themselves were not as troubling as the continuous and steady increase in the number of new addicts.

More accurate data was collected in individual cases at the local level. For example, the Department of Addiction at the University Hospital Center “Sisters of Charity” in Zagreb has epidemiologically monitored the incidence of addiction since the 1970s, indicating a steady and continuous increase in the number of newly registered addicts from the 1970s to the 1990s. Even here, until 1990, the absolute figures were not too alarming (a total of 641 new addicts), but the increase was significant especially in the last three years of that period with the significant rise of newly registered opiate addicts in 1988 [21]. Sakoman suggests that in regard to the figures, it is difficult to estimate the total number of heroin addicts, since their significant portion remained in the gray zone, avoiding treatment that was not yet based on opioid substitution programs. In addition, in some areas, such as Split, in which the uncontrolled expansion of heroin use occurred in the second half of the 1980s, no treatment program existed, which implies that there were no associated recordings [21].

Harm-reduction practices were not institutionally considered or supported until the end of this period and the addictive population at registration was referred for inpatient detox and withdrawal treatment. Since the mid-1980s, due to the coincidental spread of HIV with the uncontrolled spread of heroin addiction in major Croatian cities (Zagreb, Split), activities aimed at introducing a program of free drug paraphernalia began [21]. Its implementation started in conditions of deep mistrust: addicts had been skeptical about typically repressive official programs and often unaware of the health consequences of shared accessories; on the other side, the official actors in charge of implementation of the program often had been poorly informed about HIV infection and had hostile attitudes toward addicts based on prejudices and the long-term stigmatization of any drug use.

THE INTRODUCTION OF HARM REDUCTION

In the early 90s, the social context in Croatia was characterized by two key factors. The first refers to the beginning of the Croatian economic and political transition, i.e., the establishment of a multi-party political system and the introduction of a market economy. The second relates to the beginning of the War of Independence, which lasted until 1995. In parallel with the above-mentioned social changes, an enormous rise in epidemiological numbers occurred. For example, the number of new heroin addicts seeking treatment at the Center for Addiction at the Clinical Hospital of the Sisters of Mercy in Zagreb jumped from 80 in 1990 to 261 in 1991. A year later, 211 new addicts were recorded, and in 1993 another 289 were added [21]. The number of newly registered heroin users continued to increase until the late 1990s, when for the first time in that decade, the rise of new addicts stalled, ranging approximately between 300 and 350 new addicts. A corresponding increase has also been reported in the use of other, previously known, illicit drugs, new illicit substances (such as MDMA and legal and prescribed drugs), tobacco, alcohol, and sedatives.

Most research that sought to interpret changes in trends and incidences of drug use in Croatia during the 1990s highlighted several major, dominant social processes. Oftentimes, these are the economic and political crises of Croatian society from the late 1980s and early 1990s, the transition process, the war in Croatia [15] and the post-war period [21]. These processes are approached as causes of the evident increase in drug use, especially among young people. War, transition, crisis, devastation, etc. are elaborated as key markers of Croatia's distinctiveness compared to other countries in the world.

In that way, a basic contour of the rapid development of drug use in Croatian society in 1990s – with implicit and explicit causation – are outlined in terms of social disorganization, anomie and (youth) delinquency [15, 21, 22]. Although their analytical usefulness is enshrined in sketching the contours of the social context that significantly characterized Croatian society during the 1990s, it is possible to critically consider their determinist and reductionist theoretical framework which missed both, a number of societal features which mediated circumstances of drug use in Croatia at that time and the eventual usefulness of supranational level of analysis which could more thoughtfully relate local trends to the development of drug use in other European countries.

For example, one of the factors that are indispensable for considering the socio-cultural context of drug use in Croatia during the 1990s was the vigorous moral campaign that has integrated the alleged problem of drug use amongst the youth. In the broader process of sociocultural disruption with a socialist heritage together with the insistence on the spiritual renewal of Croatian society, campaigns to ban abortion and a promotion of increased control over the fragmentation of young people's lifestyles, particular attention has been paid to the problem of drugs, primarily through the actions of moral entrepreneurs from ruling power structures and through the media. Death, fear, punishment, expulsion, extermination, crime, illness, debauchery, hedonism, along with the associated over-dimensioning and constant promotion of sport as a desired goal, represented significant factors for understanding and action regarding drug use and addiction integral to the activities of key promoters of the moral campaign [18]. In addition, a markedly hostile attitude toward the IDU population (as well as users of other illicit drugs) was promoted through a series of suggestive, but inaccurate information. For example, the statement on 20 000 heroin addicts in Split that was given by the most prominent moral crusader at that time was broadcasted in the most of media, while, at the same time, the study made by Psychiatry Department of University Hospital "Firule" in Split and "Pulse" research agency, which referred to approximately 1500-2 000 IDU users in Split had went almost unnoticed [23].

However, although it included all the key elements in the concept of moral panic, such as distortion, exaggeration, divination, symbolization, and advocacy of a repressive normative framework [24, 25], the moral campaign did not stop the development of several harm reduction practices, which since their beginnings in early organized forms of actions were embedded in the public health perspective and appropriately institutionalized.

Namely, as early as the second half of the 1980s, the first educational measures were taken by the existing treatment system with the purpose of helping heroin addicts in preventing the spread of HIV. At the turn of the 1990s, an internal agreement was reached with pharmacies regarding the unrestricted purchase of supplies for intravenous use, thereby opening guidelines for further action to maintain the number of HIV seropositive part of the IDU population below 1 % [21]. At the same time and for the same reasons, the application of the opioid-substitution (methadone) program as a public-health activity had begun at the University Hospital Center "Sisters of Charity" in Zagreb. Initially, it was evident that heroin users were accepting the aforementioned changes in the work of official bodies and, according to the methadone

program providers themselves, the huge increase in the number of new registered addicts in the early 1990s could be partly explained by the registration of already existing heroin users who previously had avoided hospital-type treatment, considering the existing drug-free and abstinence programs to be inappropriate [21]. In addition, Sakoman suggests that some of the newly registered heroin users actually had previously joined the methadone maintenance program in Belgrade. When Yugoslavia broke up and the ties with Belgrade were cut, a number of heroin users from Croatia decided to continue methadone maintenance therapy in newly established programs in Zagreb.

According to Sakoman [21], the first interdepartmental commission was established at the Ministry of Health in 1991 to design and implement a national drug abuse prevention program. Three years later, the Commission for the Suppression of Drug Abuse was established under the Government of the Republic of Croatia, proposing the first National Strategy on Combating Drug Abuse in 1995.

Harm reduction became part of a national strategy primarily through facilitating and encouraging free needle exchanges to prevent the spread of HIV and Hepatitis C (HCV) and to mitigate the criminalization and stigmatization of heroin users. Harm reduction was interpreted predominantly in terms of a cost-benefit analysis (less contagion, less burdening of judicial and the prison system etc.). In fact, in some ways, the authors of the strategy legitimized harm reduction through the open recognition that all drug treatment and rehabilitation programs are essentially an attempt to reduce the harmful effects of drug use [11]. The intention was to approach hard-to-reach segments of the IDU population, so harm reduction was considered as an integral part of a wider range of outreach programs in the health and social care system. Also, unconventional actions are envisaged while respecting the basic harm reduction strategy and avoiding the classic casework that was prevalent in services dealing with this issue [11]. Finally, it was undoubtedly pointed to the ineffectiveness of the repressive system, that is to the disputed parts of the then Criminal Code, which did not clearly delineate possession of drugs for personal use from possession of drugs for the purpose of illegal trafficking. The strategy proposed that the possession of one dose on which the individual is dependent should be treated as a misdemeanor, and that each other possession, depending on the type and quantity, can be proportionately sanctioned [11].

Non-governmental organizations began with harm reduction activities in the early 1990s. First, “HELP” was founded in Split in 1992 and focused on replacing accessories, voluntary counseling, testing for HIV and HCV, distributing educational materials, providing free condoms, raising public awareness about HIV and AIDS, and caring for people with HIV [26]. The Croatian Red Cross as a non-profit legal entity began implementing a harm reduction policy in 1998 in Zagreb, Zadar, and Pula through the needle exchange and other programs for the replacement of accessories, which active intravenous drug users needed. All activities were undertaken at fixed locations and through field work [10].

Overall, the 1990s represent a period of establishing harm reduction programs in Croatia in terms of public health perspectives. The whole process took place at a time of rapid increase in drug use, war events, and in a social climate in which drug users were exposed to substantial marginalization and criminalization. Nevertheless, the two constituent elements of harm reduction, the opioid substitution program, and the needle exchange activities are legitimized as an integral part of the government’s official drug abuse program.

RECENT DEVELOPMENTS

After a brief stabilization of the number of opiate users in the late 90s, their numbers have continued to grow throughout the first decade of the 2000s. Similarly, other drug-use surveys

indicate an increase in experimentation and recreational use [27], as well as specific changes in trends and patterns of use among adolescents as a predominantly examined population [28]. However, since 2012, the number of registered opiate users has stabilized with a slight decline in the coming years (Table 1). Also, the number of newly registered opiate users has declined significantly since 2009, while their share has been on a significant decline since 2006, suggesting that the most-treated opiate users have been in some form of treatment for several years. The age of registered users increased from 29,7 in 2007 to 37,3 in 2017 [29].

Table 1. The number of treated, first-time treated, and the share of first-time treated opiate users in Croatia from 2000 to 2017. Source: Croatian Institute for Public Health (adapted overview).

Year	The number of all people treated for opiates	Opiate users treated for the first time	The share of first time treated in total number of persons treated for opiates (%)
2000	2 520	1009	40,0
2001	3 067	1066	34,8
2002	4 061	846	20,8
2003	4 087	802	19,6
2004	4 163	732	17,6
2005	4 867	785	16,1
2006	5 611	876	15,6
2007	5 703	800	14,0
2008	5 832	769	13,2
2009	6 251	667	10,7
2010	6 175	430	6,7
2011	6 198	343	5,5
2012	6 357	313	4,9
2013	6 315	270	4,3
2014	6 241	205	3,3
2015	6 123	175	2,8
2016	5 953	178	3,0
2017	5 773	204	3,5

Overall, from 2000 onwards, the total number of people taking heroin in Croatia is estimated at 10 000-13 000, assuming that approximately 50 % of them are in some form of medical treatment [21]. A similar framework for estimating the number of heroin users is presented by Andrijašević and Lalić, in an analysis of the effects of public policy in addressing the problem of addiction in Split [30].

In most studies, drugs are viewed negatively in terms of abuse and the unintended consequences for society and the individual [21, 28]. The social context of drug use has not been specifically investigated in the 2000s, and this is not the focus of epidemiological overviews. Predominantly anomie-based explanations from 1990s with references to wartime events, the socio-economic crisis, and the political transition of Croatian society have given way to approaches that view drug use as a worldwide phenomenon and one of the major problems in public health [21, 31]. In a way, this interpretative turn was expected since Croatian society was undergoing economic growth and recovery during the 2000s, and gradual adjustments were made to the practical realization of multiparty political system and to wider involvement in the European integration processes. However, the economic and financial crisis that hit Croatian society in 2009-2014 coincided with the first significant stabilization of the number of registered and new opioid users, and with a decrease in that number during and after the

crisis. In other words, just as Croatia's economic recovery in the early 2000s did not halt epidemic growth, neither did the economic crisis of 2009-2014 accelerate this long-term growth, but it simply coincided with the beginning of its long-standing decline.

Some explanations for these developments are based on a consideration of supply-and-demand dynamics, arguing that the repressive system's services, by focusing on significant smuggling chains and actors, have successfully reduced the supply of heroin in the domestic illicit drug market [21]. In addition, it has been claimed that the recent decline in heroin use in Croatia is the outcome of a long-term development of those aspects of Croatian drug policy, which some authors consider as the specific national model of opiate addiction treatment. Its organizational parts largely involve the active role of family physicians and their ongoing collaboration with teams in the centers for the prevention and outpatient treatment of opiate addicts. Substitution therapy has also been covered by regular health insurance, which has enabled many heroin users to access these programs for free or inexpensively. In this way, it was possible to reduce the need for hospitalization and to include a number of elements in the therapeutic procedure - from pharmacotherapy, i.e. opioid replacement therapy, to measures aimed at preventing the spread of viral diseases [32]. These developments suggest that the system of prevention and treatment of the IDU population have developed somewhat independently of the strictly economic changes in the immediate social environment. Therefore, the previously mentioned interpretations in which drug use and the epidemiological development of opiate addiction during the 1990s have been approached as related almost exclusively to the issues of socio-economic crisis and transition could be theoretically and empirically challenged.

The concept of transition as the analytical tool for considering the dynamics of Croatian social development has been challenged in a number of other studies [33], with critical considerations related to its inherently reductionist and teleological understanding of social development. However, there has been little social research on drug use since the 2000s, with transition and socioeconomic development being only sporadically affected. Andrijašević and Lalić analyzed public policy elements in sociohistorical research regarding the issue of drug addiction in Split, determining the rise of heroin use in the 1980s in terms of social crisis and a sense of "hopelessness" in the final years of the socialist political order, but also indicating the elements of normality in terms of perceived drug use among the youth population at that time and the importance of linking grass-roots initiatives with local and state institutions in identifying and organizing harm reduction practices during the 1990s [30]. In a study focusing on cannabis use in Croatia, the socio-cultural context was considered a departure from anomie-based approaches, and viewed more in terms of the relationship between, on the one hand, normalizing aspects of cannabis use already clearly visible in Croatian society and, on the other, the regressive aspects of societal reaction aimed at the criminalization and stigmatization of drug use in general [18].

Moreover, the institutionalization of harm reduction since 2000 has been marked by pronounced decentralization and the gradual establishment of governmental offices for the implementation of opiate treatments at the regional level and by the development of civil society organizations at the local level. Since it has been followed by the involvement of family medicine physicians, almost all local and regional critical areas in Croatia are covered over the last twenty years. However, the dynamics of this process are mediated by political developments at the societal level, most notably in political struggles for power, which had reflected some key elements in the process of creating the entire drug policy. In the early 2000s, these struggles culminated in the wide public debate among actors who aimed at the position of the Head of the Government Drug Office. Different stances have most clearly manifested through conflict between, on the one hand, actors who advocated greater emphasis on the introduction of therapeutic

communities and strict abstinence, and, on the other, actors who had for years been implementing and advocating the methadone maintenance program and broader adoption of harm reduction activities. While it can be assumed that the outcomes of these conflicts strictly coincide with the political clash between conservative and liberal drug policies, it may be more plausible to say that this aspect of the institutionalization of harm reduction reflected much more the dislike and disinterest of the largest political parties for anything beyond the occupation of political positions, including that of the Head of the Drug Office [21].

Notwithstanding the aforementioned political aspects of institutionalization, harm reduction programs have remained an integral part of the two National Drug Abuse Strategies since 2006. However, in all of the national strategies since 1996, opioid substitution therapy is not considered in the chapter on harm reduction. It is rather seen as a part of inpatient/outpatient and psychosocial treatment of the IDU population. In technical terms, harm reduction is viewed through needle exchange and other programs aimed at attracting IDU populations to non-abstinence-based programs that are primarily aimed at improving the health status of heroin users and preventing the possible spread of blood-borne infections [11-13]. In other words, harm reduction strategies are mainly considered through expanding opportunities for the free distribution of clean syringes and the supply of other necessities, such as alcohol pads, distilled water ampoules related to safe heroin use, and the collection of impure and used injection equipment.

Since 2000, the harm reduction activities as defined in the National Drug Abuse Strategies have been largely implemented through NGO activities. There are currently six NGOs that are focused on continual and trusting contact with the active IDU population, the free exchange of needles and syringes, counseling activities, the use of libraries and the Internet, helping to reconnect addicts with their families, the distribution of information materials on infectious disease protection and safe intravenous use, the eventual reintegration of addicts through job-finding and occupational therapy, and finally, the provision of free testing for HIV and HCV [10]. The available data for the harm reduction activities of the Croatian Red Cross (Table 2) from 2009 to 2018 shows that the number of heroin users entering harm reduction have been increasing by 2012 and have declined since.

Table 2. Croatian Red Cross harm-reduction activities 2009-2018.

Year	Number of users	Syringes and needles provided	Syringes and needles collected	Other accessories provided*	Persons tested	
					HIV	HCV
2009	1962	23 934	15 612	41045	0	0
2010	2 080	25 382	9 558	54742	30	23
2011	2 985	32 334	16 935	53428	21	84
2012	2 071	28 092	9 714	74978	72	118
2013	1573	33 340	22 943	98714	87	126
2015	1931	92 677	20 214	132957	67	69
2018	1184	97 385	34 885	105770	149	111

*alcohol pads, distilled water ampoules, condoms etc

These changes have not been systematically monitored and there is currently no reliable research data as to what is happening to drug addicts over time. One can assume some users change their residence, some ends up in prisons, some pass away, and part of them simply disappear. It can be said with some certainty that the number of clients is decreasing by 2018, because epidemiologically (as elsewhere in Europe) the number of heroin addicts is decreasing, especially new ones. Generally, mainly older users remain in Croatian harm reduction programs.

Similarly, the number of new clients has yet to be systematically investigated. According to the harm reduction practitioners' field experience, working with addictive populations

involves changes that cannot always be fully explained due to the highly individualized approach to each user, with the character of this relationship with each user being crucial. This also applies to the numbers showing the amount of provided injection equipment; although this amount increases over the years, it should be noted that the drug injection method is also individual, with some users taking more needles and syringes to distribute to users who do not want to enter the program because of the fear of being recorded, the stigma, or the heroin-related sense of paranoia. When it comes to returning needles and syringes, it is known from harm reduction practice that returns are never 100 %. Although it has grown over the past few years, the return reaches levels of 35-40 % and expresses the specificities of addictive scenes which vary regionally, and by city, but also within cities. Other shared supplies are dominated by alcohol pads, because they are additionally used not only for cleansing the skin before injection, but also for the general cleaning of hands, glasses, as makeup remover, etc. Finally, oscillations are visible over the years in the number of people tested for HIV and HCV, and this suggests the uncertainty of the outcome in efforts to get users to test. Therefore, the marked increase in testing in 2018 cannot yet be seen as an indication of the change that will manifest itself in the coming years, but it may be linked to the popularization of testing by the Croatian Red Cross and the expansion of the network of free testing centers. It is informally argued by harm reduction practitioners that 50 % of testing is related to the same people, i.e., those who were negative in previous testing. Testing is anonymous, performed by rapid saliva or blood tests, by laboratory blood sampling, or by the ELISA (enzyme-linked immunosorbent assay) technique. In the case of a positive finding, users are referred for additional checks.

We have collected the available data for the harm reduction activities of NGOs throughout Croatia in 2015 and 2018. The data presented in Table 3 was collected directly from local harm reduction program providers. Considering that they are quite oscillating or unclear in details, here we can consider only the data from the Croatian Red Cross to be reliable. However, data on the number of clients, the amount of material exchanged, and the number of persons tested is presented for all harm-reduction NGOs in Croatia. On the whole, this data is provisory in the estimation of activities of harm-reduction associations in Croatia and, if anything, show that in the work with IDU population classical statistical rules do not always fit. In other words, it is rather difficult to find standard models of explanations or causes in analysis of IDU population behavior, because the scene is very flexible, prone to changes in trends, and is very specific to the individual.

In Table 3, this can already be seen in terms of the locality of NGO activity. This means that the variability in each area can be caused by factors such as the departure of users from that place of residence/stay, users going to jail, or therapeutic community treatment, or factors mediated by the character of the work of social control services, primarily the police, and by informally developed (sometimes pervading) fears and skeptical stances on the providers of harm reduction.

A certain decline in the total number of clients participating in harm reduction programs is also evident in Table 3, and it can be assumed that this data is in line with the epidemiological trends presented earlier at the national level. The population of opiate users is growing older, which may be an indicator of the quality of the system as registered users remain in some form of treatment for a long time. The future will show what will happen with intravenous injections with respect to new psychoactive drugs. Similarly, when it comes to exchanged injection accessories and other supplies, it is also extremely difficult to offer standard explanatory models. The variations among the NGOs are enormous, and the oscillations make it impossible to see a steady trend.

Table 3. Harm reduction activities by NGO in 2015 and 2018.

NGO (Area of action)	Number of users		Injection equipment provided		Injection equipment collected		Other supplies provided*		People tested for infection	
	2015	2018	2015	2018	2015	2018	2015	2018	2015	2018
Croatian Red Cross (Zagreb, Zadar, Nova Gradiška, Krapina)	1931	1184	92677	97385	20214	34885	132957	105770	136	260
Help (Split, Dubrovnik, Šibenik, Knin, Osijek, Vukovar, Varaždin)	1089	1300	618034	203069	168395	52979	21155	6338	284	150
Terra (Rijeka, Primorje-Gorski kotar County)	671	281	74816	165536	13302	51686	63732	74446	0	0
Institut (Pula, Istria County)	422	451	139730	118875	251000	283000	509784	47400	0	0
Neovisnost (Osijek)	42	304	1560	1224	578	964	965	5872	25	0
Let (City of Zagreb, Zagreb County)	650	150	137923	175000	31346	25500	99788	92500	0	0
Total	4805	3760	1064740	761089	484835	449014	828381	332326	445	410

*alcohol pads, distilled water ampoules, condoms etc

Therefore, there is a certain need to conduct research that would gather more reliable data and offer more comprehensive explanations. When it comes to the number of people tested for HIV and HCV, there was a notable drop in testing rates at the Croatian Red Cross in 2018, because some of these activities (for example, in Zadar) have been taken over by the local Public Health Institute. Other organizations carry out tests periodically, mainly in consultation with local public health institutes and do not have continuity of testing.

According to the practitioners involved in the implementation of harm reduction programs, distrust and resistance to social institutions still dominate the attitudes of heroin users. Such a stance is supported by rigid repressive practices and penal policies, which increase the possibility of identifying addicts with criminals [10]. In addition, rejection, marginalization, and stigma have supported the neglect of the addiction by the highly bureaucratized welfare and health systems.

CONCLUDING REMARKS

The development of harm reduction in Croatia can be viewed as public health concern in regard to drug policy that was primarily aimed at preventing the strong epidemiological growth of heroin use. Up until the early 1990s, this growth was seen as a potentially greater

challenge than the total IDU population, and the linkage of addiction to blood-borne infections was a key element in the first initiatives to introduce harm reduction under conditions where the abstinence-oriented paradigm left no room for its own questioning. The huge leaps in the number of registered heroin users in the early 1990s and their continued growth until the middle of the first decade in the new millennium can be seen as a key element in the introduction of part of the harm reduction practices in Croatia, most notably opioid substitution therapy and needle exchange programs.

In explaining steady epidemiological growth, a number of studies approached the social context through a narrow explanatory pattern focused predominantly on the economic and political problems that Croatian society has faced in the late 1980s and through the 1990s. Its major weaknesses can be identified in the relatively poor shading of economic and transitional elements as determinants of changes in drug trends that have not only been seen in Croatia but also worldwide and in the pronounced determinism that viewed socioeconomic developments as a key indicator for the growth of drug use. On the one hand, this means that the anomie/transition approach remained concentrated on illicit drugs with no broader elaboration of the relationship of Croatian social specificities with the use of alcohol, sedatives and tobacco-nicotine. On the other hand, in the case of drugs as a whole, such an approach missed the opportunity to consider the Croatian context of drug use in comparison with its significant increase in use, which was evident in different transition countries, as well as in the European Union and the United States in the 1990s [34, 35]. Finally, the increase in drug use was evident in the period from the beginning of the 2000s and occurred independently of the economic stabilization of Croatian society, while significant indicators of the decline in the number of new addicts have coincided with the beginning of the economic crisis in 2009. In summary, that anomie based approach is problematic in solving the problem of addiction and drugs has been pointed out a long time ago [36] through the appreciation of a multitude of drug-focused motives beyond those caused by anomie and withdrawal, and by pointing out that, in slightly more Durkhemian terms, it can be assumed to be quite the opposite – that addiction (heightened by alienation and despair) can lead to anomie.

Despite the war, problematic privatization, rising unemployment, and falling standards of living [15], it is precisely in transitional conditions that opportunities for the pluralization of drug discourse had begun to open. This also applies to the institutionalization of harm reduction practices that, in these circumstances, have become an integral part of Croatian drug policy.

If something can be significant for further developments in harm reduction, then it is related to the character of its institutionalization, which integrated harm reduction into a prohibitionist drug policy, primarily through a pronounced decentralization and incorporation of a social component without which these programs would remain financially unavailable to the most of IDU population. Decentralization has enabled the development of a network of non-governmental organizations and other activities within the health system and can perhaps be seen as one of the most important factors in the development of harm reduction in Croatia. The process, which began in the mid-90s, has resulted in strong developments in the coming decades where, through the combined action of NGOs and governmental organizations, local action and addressing addiction in the field are strengthened. In this way, it was possible to face the problem of addiction in the field head-on through direct work with the IDU population and its gradual inclusion in the programs, which it still approaches with fear and skepticism. However, as was evident in the early 2000s, political disputes in the formulation of drug policy in Croatia did not crucially limit the further development of harm reduction programs, so today it is not entirely certain to predict future developments, since government action in this area is often and still fairly opportunistic (especially with regard to financing), while harm reduction program

providers in the field still have to unequivocally confirm their credibility in dealing with the IDU population while adapting to changes in trends of drug use; perhaps most notable in the problems currently manifested in the emergence of new psychoactive substances.

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